December 6, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0351-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on ___ external review panel. This physician is board certified in anesthesiology. ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 34 year-old female who sustained a work related injury along the cervical spine, between the shoulder blades and along the left shoulder. This injury is associated with lifting. The patient has had two MRI scans of the cervical spine and is diagnosed as having a cervical strain. Treatments have included physical therapy, medications, work conditioning, biofeedback, and trigger point injections.

Requested Services

Proposed Pain Management Program times 30 sessions.

Decision

The Carrier's denial of authorization and coverage for the requested services is overturned.

Rationale/Basis for Decision

___ physician reviewer noted that a review of the medical records provided indicated the patient sustained a work related injury on ___ along the cervical spine between the shoulder blades and along the left shoulder. ___ physician reviewer also noted that the patient experiences pain from this injury. ___ physician reviewer further noted that the patient has been treated with conservative therapies including multiple medications, physical therapy, work conditioning, ultrasound treatments, biofeedback, and trigger point injections with minimal positive results. ___ physician reviewer indicates the patient has a myofacial pain syndrome that has not responded to conservative and interventional therapies. ___ physician reviewer also indicates

that one of the characteristics of this syndrome is the continuance of pain and failure of traditional approaches for long periods of time, and that patients vary in their responses to different treatment techniques. ___ physician reviewer further indicates that a trial of different therapies is often necessary due to the fact that this syndrome can have behavioral, biologic, and mechanical contributing factors and a failure to recognize or treat these factors may perpetuate muscle restriction and tension, leading to recurring trigger points. ___ physician reviewer explained that the proposed chronic pain program involves a structured multidisciplinary approach to the patient's chronic pain syndrome. ___ physician reviewer also explained that review of the medical records indicated that attempts at prolonged pain control with numerous modalities have not been successful. Therefore, ___ physician consultant concluded that the request for enrollment in a chronic pain management program is medically necessary for the treatment of this patient's condition.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,